CIBMTR®
CENTER FOR INTERNATIONAL BLOOD & MARROW TRANSPLANT RESEARCH

# Pre-Transplant Essential Data

**CIBMTR Use Only**

Sequence Number:

Date Received:

~~**(Request for OMB approval will be submitted when form is complete)**~~

**OMB Placeholder**

OMB No: ~~0915-0310~~
Expiration Date:

**Public Burden Statement:** An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0915-0310.

## Center Identification

CIBMTR Center Number: ___ ___ ___ ___ ___

EBMT Code (CIC): ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Hospital: _____

Unit: (check only one)

- ☐ Adult
- ☐ Pediatric

## Recipient Identification

CIBMTR Research ID (CRID): ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

## Recipient Data

CIBMTR Center Number: ___ ___ ___ ___ ___ CIBMTR Research ID: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

1. Date of birth: ___ ___ ___ ___ — ___ ___ — ___ ___

YYYY MM DD

Sex:

- ☐ Male
- ☐ Female

Ethnicity:

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Not applicable (not a resident of the USA)
- ☐ Unknown

Race:

- ☐☐White
- ☐☐Black or African American
- ☐☐Asian
- ☐☐American Indian or Alaska Native
- ☐☐Native Hawaiian or Other Pacific Islander
- ☐☐Not reported
- ☐☐Unknown

**Copy question 4 to report more than one race.**

Zip or postal code for place of recipient's residence (USA recipients only): ___ ___ ___ ___ ___

Is the recipient participating in a clinical trial?

- ☐ Yes - ***Go to question 7***
- ☐ No – ***Go to question 11***

7. Study Sponsor:
   - ☐ BMT-CTN – ***Go to question 9***
   - ☐ RCI-BMT – ***Go to question 9***
   - ☐ USIDNET – ***Go to question 10***
   - ☐ COG – ***Go to question 10***
   - ☐ Other sponsor – ***Go to question 8***

8. Specify other sponsor: _____ ***- Go to question 10***

9. Study ID Number: _____

CIBMTR Center Number: ___ ___ ___ ___ ___ CIBMTR Research ID: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

10. Subject ID: _____

**Copy questions 7-10 to report participation in more than one study.**

## Hematopoietic Cellular Transplant (HCT)

11. Date of this HCT: ___ ___ ___ ___ — ___ ___ — ___ ___
YYYY MM DD

Was this the first HCT for this recipient?

- ☐ Yes – ***Go to question 13***
- ☐ No – ***Go to question 15***

13. Is a subsequent HCT planned as part of the overall treatment protocol (not as a reaction to post-HCT disease assessment)? **(For autologous HCTs only)**

- ☐ Yes – ***Go to question 14***
- ☐ No – ***Go to question 29***

14. _____Specify subsequent HCT planned:

- ☐ Autologous – ***Go to question 29***
- ☐ Allogeneic – ***Go to question 29***

15. _____Specify the number of prior HCTs: ___ ___

**Specify the HSC source(s) for all prior HCTs:**

16. _____Autologous

- ☐ Yes
- ☐ No

17. _____Allogeneic, unrelated

- ☐ Yes
- ☐ No

18. _____Allogeneic, related

- ☐ Yes
- ☐ No

19. _____Syngeneic

- ☐ Yes
- ☐ No

20._____Date of the last HCT (just before current HCT): ___ ___ ___ ___ — ___ ___ — ___ ___
YYYY MM DD

21._____Was the last HCT performed at a different institution?

☐ Yes – ***Go to question 22***

☐ No – ***Go to question 23***

**Specify the institution that performed the last HCT:**

22. Name: _____

City: _____

State: _____

Country: _____

23._____What was the HSC source for the last HCT?

☐ Autologous

☐ Allogeneic, unrelated donor

☐ Allogeneic, related donor

24._____Reason for current HCT:

☐ No hematopoietic recovery – ***Go to question 29***

☐ Partial hematopoietic recovery – ***Go to question 29***

☐ Graft failure / rejection after achieving initial hematopoietic recovery – ***Go to question 25***

☐ Persistent primary disease – ***Go to question 29***

☐ Recurrent primary disease – ***Go to question 26***

☐ Planned second HCT, per protocol – ***Go to question 29***

☐ New malignancy (including PTLD and EBV lymphoma) – ***Go to question 27***

☐ Stable, mixed chimerism – ***Go to question 29***

☐ Declining chimerism – ***Go to question 29***

☐ Other – ***Go to question 28***

25.__Date of graft failure / rejection: ___ ___ ___ ___ — ___ ___ — ___ ___ – ***Go to question 29***
YYYY MM DD

26._____Date of relapse: ___ ___ ___ ___ — ___ ___ — ___ ___ – ***Go to question 29***
YYYY MM DD

27.__Date of secondary malignancy: ___ ___ ___ ___ — ___ ___ — ___ ___ – ***Go to question 29***
YYYY MM DD

28._____Specify other reason:

## Donor Information

. Multiple donors?

- ☐ Yes – ***Go to question 30***
- ☐ No - ***Go to question 31***

30. Specify number of donors: ___ ___

***To report more than one donor, copy questions 31- 63 and complete for each donor.***

. Specify donor:

- ☐ Autologous - ***Go to question 46***
- ☐ Autologous cord blood unit - ***Go to question 35***
- ☐ NMDP unrelated cord blood unit - ***Go to question 32***
- ☐ NMDP unrelated donor - ***Go to question 33***
- ☐ Related donor - ***Go to question 40***
- ☐ Related cord blood unit - ***Go to question 35***
- ☐ Non-NMDP unrelated donor ***- Go to question 34***
- ☐ Non-NMDP unrelated cord blood unit - ***Go to question 35***

32. NMDP cord blood unit ID: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ – ***Go to question 46***

33. NMDP donor ID: ___ ___ ___ ___ — ___ ___ ___ ___ — ___ ***Go to question 46***

34. Non-NMDP unrelated donor ID: (not applicable for related donors)

___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ - ***Go to question 38***

35. Non-NMDP cord blood unit ID: (include related and autologous CBUs)

___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

36. Is the CBU ID also the ISBT DIN number?

- ☐ Yes – ***Go to question 38***
- ☐ No – ***Go to question 37***

37. Specify the ISBT DIN number: _____

38. Registry or UCB Bank ID: ___ ___ ___ ___ ***- If 'Other registry' go to 39, otherwise go to question 41***

39. Specify other Registry or UCB Bank: _____ - ***Go to question 41***

40. Specify the related donor type:

- ☐ Syngeneic (monozygotic twin)
- ☐ HLA-identical sibling (may include non-monozygotic twin)
- ☐ HLA-matched other relative
- ☐ HLA-mismatched relative

41. Date of birth: (donor / infant)

- ☐ Known – ***Go to question 42***
- ☐ Unknown ***– Go to question 43***

42. Date of birth: (donor / infant) ___ ___ ___ ___ — ___ ___ — ___ ___ - ***Go to question 45***
YYYY MM DD

43. Age: (donor / infant)

- ☐ Known – ***Go to question 44***
- ☐ Unknown – ***Go to question 45***

44. Age: (donor / infant) ___ ___ ☐ Months (use only if less than 1 year old)
☐ Years

45. Sex: (donor / infant)

- ☐ Male
- ☐ Female

**Specify product type:**

. Bone marrow:

- ☐ Yes
- ☐ No

. PBSC:

- ☐ Yes
- ☐ No

. Single cord blood unit:

- ☐ Yes
- ☐ No

Other product:

- ☐ Yes – ***Go to question 50***
- ☐ No – ***Go to question 51***

50. Specify other product type: _____

**A series of collections should be considered a single product when they are all from the same donor and use the same collection method and technique (and mobilization, if applicable), even if the collections are performed on different days.**

Specify number of products infused from this donor: ___ ___

Specify the number of these products intended to achieve hematopoietic engraftment: ___ ___

**Questions 53 – 60 are for autologous HCT recipients only. If other than autologous skip to question 61**

Did the recipient have more than one mobilization event to acquire cells for HCT?

- ☐ Yes – ***Go to question 54***
- ☐ No **– *Go to question 55***

54. Specify the total number of mobilization events performed for this HCT (regardless of the number of collections or which collections were used for this HCT): ___

**Specify all agents used in the mobilization events reported above:**

G-CSF

- ☐ Yes
- ☐ No

GM-CSF

- ☐ Yes
- ☐ No

Pegylated G-CSF

- ☐ Yes
- ☐ No

Plerixafor (Mozobil)

- ☐ Yes
- ☐ No

. Other CXCR4 inhibitor

- ☐ Yes
- ☐ No

. Combined with chemotherapy:

- ☐ Yes
- ☐ No

. Was this donor used for any prior HCTs?

- ☐ Yes
- ☐ No

. Donor CMV-antibodies (IgG or Total) **(Allogeneic HCTs only)**

- ☐ Reactive
- ☐ Non-reactive
- ☐ Not done
- ☐ Not applicable (cord blood unit)

. Was plerixafor (Mozobil) given at any time prior to the preparative regimen? **(Related HCTs only)**

- ☐ Yes
- ☐ No
- ☐ Unknown

## Consent

. Has the recipient signed an IRB-approved consent form for submitting research data to the NMDP / CIBMTR?

- ☐ Yes (patient consented) – ***Go to question 65***
- ☐ No (patient declined) – ***Go to question 66***
- ☐ Not approached – ***Go to question 66***

65. Date form was signed: ___ ___ ___ ___ — ___ ___ — ___ ___

YYYY MM DD

. Did the recipient give permission to be directly contacted for future research?

- ☐ Yes (patient provided permission) – ***Go to question 67***
- ☐ No (patient declined) – ***Go to question 68***
- ☐ Not approached - ***Go to question 68***

67. Date form was signed: ___ ___ ___ ___ — ___ ___ — ___ ___
YYYY MM DD

Has the recipient signed an IRB-approved consent form to donate research blood samples to the NMDP / CIBMTR?

- ☐ Yes (patient consented) – ***Go to question 69***
- ☐ No (patient declined) - ***Go to question 70***
- ☐ Not approached - ***Go to question 70***
- ☐ Not applicable (center not participating) - ***Go to question 70***

69. Date form was signed: ___ ___ ___ ___ — ___ ___ — ___ ___
YYYY MM DD

Has the donor signed an IRB-approved consent form to donate research blood samples to the NMDP / CIBMTR? **(Allogeneic donors only)**

- ☐ Yes (donor consented) – ***Go to question 71***
- ☐ No (donor declined) - ***Go to question 72***
- ☐ Not approached - ***Go to question 72***
- ☐ Not applicable (center not participating) - ***Go to question 72***

71. Date form was signed: ___ ___ ___ ___ — ___ ___ — ___ ___
YYYY MM DD

## Product Processing / Manipulation

Was the product manipulated prior to infusion?

- ☐ Yes - ***Go to questions 73***
- ☐ No - ***Go to question 91***

73. Specify portion manipulated:
- ☐ Entire product
- ☐ Portion of product

**Specify all methods used to manipulate the product:**

74. Washed
- ☐ Yes
- ☐ No

75._____Diluted

☐ Yes

☐ No

76._____Buffy coat enriched (buffy coat preparation)

☐ Yes

☐ No

77._____B-cell reduced

☐ Yes

☐ No

78._____CD8 reduced

☐ Yes

☐ No

79._____Plasma reduced (removal)

☐ Yes

☐ No

80._____RBC reduced

☐ Yes

☐ No

81._____Cultured (ex-vivo expansion)

☐ Yes

☐ No

82._____Genetic manipulation (gene transfer / transduction)

☐ Yes

☐ No

83._____PUVA treated

☐ Yes

☐ No

84._____CD34 enriched (CD34+ selection)

☐ Yes

☐ No

85._____CD133 enriched

☐ Yes

☐ No

86._____Monocyte enriched

☐ Yes

☐ No

87._____Mononuclear cells enriched

☐ Yes

☐ No

88._____T-cell depletion

☐ Yes

☐ No

89._____Other cell manipulation

☐ Yes - ***Go to question 90***

☐ No - ***Go to question 91***

90._____Specify other cell manipulation:

## Clinical Status of Recipient Prior to the Preparative Regimen (Conditioning)

What scale was used to determine the recipient's functional status?

☐ Karnofsky (recipient age ≥ 16 years) ***– Go to question 92***

☐ Lansky (recipient age < 16 years) ***– Go to question 93***

### Performance score prior to the preparative regimen:

92. Karnofsky Scale (recipient age ≥ 16 years):

☐ 100 Normal; no complaints; no evidence of disease - ***Go to question 94***

☐ 90 Able to carry on normal activity - ***Go to question 94***

☐ 80 Normal activity with effort - ***Go to question 94***

☐ 70 Cares for self; unable to carry on normal activity or to do active work - ***Go to question 94***

☐ 60 Requires occasional assistance but is able to care for most needs - ***Go to question 94***

☐ 50 Requires considerable assistance and frequent medical care - ***Go to question 94***

☐ 40 Disabled; requires special care and assistance - ***Go to question 94***

☐ 30 Severely disabled; hospitalization indicated, although death not imminent - ***Go to question 94***

- ☐ 20 Very sick; hospitalization necessary - ***Go to question 94***
- ☐ 10 Moribund; fatal process progressing rapidly - ***Go to question 94***

93. Lansky Scale (recipient age < 16 years):

- ☐ 100 Fully active
- ☐ 90 Minor restriction in physically strenuous play
- ☐ 80 Restricted in strenuous play, tires more easily, otherwise active
- ☐ 70 Both greater restrictions of, and less time spent in, active play
- ☐ 60 Ambulatory up to 50% of time, limited active play with assistance / supervision
- ☐ 50 Considerable assistance required for any active play; fully able to engage in quiet play
- ☐ 40 Able to initiate quiet activities
- ☐ 30 Needs considerable assistance for quiet activity
- ☐ 20 Limited to very passive activity initiated by others (e.g., TV)
- ☐ 10 Completely disabled, not even passive play

. Recipient CMV-antibodies (IgG or Total) :

- ☐ Reactive
- ☐ Non-reactive
- ☐ Not done

## Comorbid Conditions

. Is there a history of mechanical ventilation?

- ☐ Yes
- ☐ No

. Is there a history of proven invasive fungal infection?

- ☐ Yes
- ☐ No

97. Were there ***clinically significant*** co-existing diseases or organ impairment at time of patient assessment prior to preparative regimen? *Source: Blood, 2005 Oct 15;106(8):2912-2919*

- ☐ Yes - ***Go to questions 98***
- ☐ No - ***Go to question 135***

98.___Arrhythmia **— For example, any history of atrial fibrillation or flutter, sick sinus syndrome, or ventricular arrhythmias requiring treatment**

- ☐ Yes
- ☐ No

☐ Unknown

99. Cardiac **— Any history of coronary artery disease (one or more vessel-coronary artery stenosis requiring medical treatment, stent, or bypass graft), congestive heart failure, myocardial infarction, OR ejection fraction ≤ 50% on the most recent test**

☐ Yes

☐ No

☐ Unknown

100. Cerebrovascular disease **— Any history of transient ischemic attack, subarachnoid hemorrhage or cerebrovascular accident**

☐ Yes

☐ No

☐ Unknown

101. Diabetes **— Requiring treatment with insulin or oral hypoglycemics in the last 4 weeks but not diet alone**

☐ Yes

☐ No

☐ Unknown

102._____Heart valve disease **— Except asymptomatic mitral valve prolapse**

☐ Yes

☐ No

☐ Unknown

103. Hepatic, mild **— Chronic hepatitis, bilirubin > upper limit of normal to 1.5 × upper limit of normal, or AST/ALT > upper limit of normal to 2.5 × upper limit of normal at the time of transplant OR any history of hepatitis B or hepatitis C infection**

☐ Yes

☐ No

☐ Unknown

104. Hepatic, moderate / severe **— Liver cirrhosis, bilirubin > 1.5 × upper limit of normal, or AST/ALT > 2.5 × upper limit of normal**

☐ Yes

☐ No

☐ Unknown

105. Infection **— For example, documented infection, fever of unknown origin, or pulmonary nodules requiring continuation of antimicrobial treatment after day 0**

☐ Yes

☐ No

☐ Unknown

106.Inflammatory bowel disease **— Any history of Crohn's disease or ulcerative colitis requiring treatment**

☐ Yes

☐ No

☐ Unknown

107._____Obesity **— Patients with a body mass index > 35 kg/m$^2$ at time of transplant**

☐ Yes

☐ No

☐ Unknown

108.___Peptic ulcer **— Any history of peptic ulcer confirmed by endoscopy and requiring treatment**

☐ Yes

☐ No

☐ Unknown

109._Psychiatric disturbance **— For example, depression, anxiety, bipolar disorder or schizophrenia requiring psychiatric consult or treatment in the last 4 weeks**

☐ Yes

☐ No

☐ Unknown

110.Pulmonary, moderate **— Corrected diffusion capacity of carbon monoxide and/or FEV$_1$ 66-80% or dyspnea on slight activity at transplant**

☐ Yes

☐ No

☐ Unknown

111.Pulmonary, severe **— Corrected diffusion capacity of carbon monoxide and/or FEV$_1$ ≤ 65% or dyspnea at rest or requiring oxygen at transplant**

☐ Yes

☐ No

☐ Unknown

112.Renal, moderate / severe **— Serum creatinine > 2 mg/dL or > 177 µmol/L or on dialysis at transplant, OR prior renal transplantation**

☐ Yes

☐ No

☐ Unknown

113.Rheumatologic **— For example, any history of systemic lupus erythmatosis, rheumatoid arthritis, polymyositis, mixed connective tissue disease, or polymyalgia rheumatica requiring treatment (do NOT include degenerative joint disease, osteoarthritis)**

☐ Yes

☐ No

☐ Unknown

114.Solid tumor, prior **— Treated at any time point in the patient's past history, excluding non-melanoma skin cancer, leukemia, lymphoma or multiple myeloma**

☐ Yes – ***Go to question 115***

☐ No – ***Go to question 133***

☐ Unknown – ***Go to question 133***

115. Breast cancer

☐ Yes ***– Go to question 116***

☐ No ***– Go to question 117***

116. Year of diagnosis: ___ ___ ___ ___

117. Central nervous system (CNS) malignancy (glioblastoma, astrocytoma)

☐ Yes ***– Go to question 118***

☐ No ***– Go to question 119***

118. Year of diagnosis: ___ ___ ___ ___

119. Gastrointestinal malignancy (colon, rectum, stomach, pancreas, intestine)

☐ Yes ***– Go to question 120***

☐ No ***– Go to question 121***

120. Year of diagnosis: ___ ___ ___ ___

121. Genitourinary malignancy (kidney, bladder, ovary, testicle, genitalia, uterus, cervix)

☐ Yes ***– Go to question 122***

☐ No ***– Go to question 123***

122. Year of diagnosis: ___ ___ ___ ___

123. Lung cancer

☐ Yes ***– Go to question 124***

☐ No **– *Go to question 125***

124. Year of diagnosis: ___ ___ ___ ___

125. Melanoma

☐ Yes **– *Go to question 126***

☐ No **– *Go to question 127***

126. Year of diagnosis: ___ ___ ___ ___

127. Oropharyngeal cancer (tongue, buccal mucosa)

☐ Yes **– *Go to question 128***

☐ No **– *Go to question 129***

128. Year of diagnosis: ___ ___ ___ ___

129. Sarcoma

☐ Yes **– *Go to question 130***

☐ No **– *Go to question 131***

130. Year of diagnosis: ___ ___ ___ ___

131. Thyroid cancer

☐ Yes **– *Go to question 132***

☐ No **– *Go to question 133***

132. Year of diagnosis: ___ ___ ___ ___

133._____Other co-morbid condition

☐ Yes – ***Go to question 134***

☐ No – ***Go to question 135***

☐ Unknown – ***Go to question 135***

134._____Specify other co-morbid condition:

135. Was there a history of malignancy (hematologic or non-melanoma skin cancer) other than the primary disease for which this HCT is being performed?

☐ Yes – ***Go to question 136***

☐ No – ***Go to question 156***

**Specify which malignancy(ies) occurred:**

136._____Acute myeloid leukemia (AML / ANLL)

☐ Yes – ***Go to question 137***

☐ No – ***Go to question 138***

137. Year of diagnosis: ___ ___ ___ ___

138._____Other leukemia, including ALL

☐ Yes – ***Go to questions 139***

☐ No – ***Go to question 141***

139._____Year of diagnosis: ___ ___ ___ ___

140._____Specify leukemia:

141._____Clonal cytogenetic abnormality without leukemia or MDS

☐ Yes – ***Go to question 142***

☐ No – ***Go to question 143***

142._____Year of diagnosis: ___ ___ ___ ___

143. Hodgkin disease

☐ Yes – ***Go to question 144***

☐ No – ***Go to question 145***

144._____Year of diagnosis: ___ ___ ___ ___

145._____Lymphoma or lymphoproliferative disease

☐ Yes – ***Go to questions 146***

☐ No – ***Go to question 148***

146._____Year of diagnosis: ___ ___ ___ ___

147._____Was the tumor EBV positive?

☐ Yes

☐ No

148._____Other skin malignancy (basal cell, squamous)

☐ Yes – ***Go to questions 149***

☐ No – ***Go to question 151***

149._____Year of diagnosis: ___ ___ ___ ___

150._____Specify other skin malignancy:

151. Myelodysplasia (MDS) / myeloproliferative (MPN) disorder

- ☐ Yes – ***Go to question 152***
- ☐ No – ***Go to question 153***

152._____Year of diagnosis: ___ ___ ___ ___

153._____Other prior malignancy

- ☐ Yes – ***Go to questions 154***
- ☐ No – ***Go to question 155***

154._____Year of diagnosis: ___ ___ ___ ___

155._____Specify other prior malignancy:

## Pre-HCT Preparative Regimen (Conditioning)

156. Height at initiation of pre-HCT preparative regimen: ___ ___ ___ ☐ inches ☐ centimeters

7. Actual weight at initiation of pre-HCT preparative regimen: ___ ___ ___ ☐ pounds ☐ kilograms

8. Was a pre-HCT preparative regimen prescribed?

- ☐ Yes – ***Go to questions 159***
- ☐ No – ***Go to question 317***

159._____Classify the recipient's prescribed preparative regimen:

- ☐ Myeloablative
- ☐ Non-myeloablative (NST)
- ☐ Reduced intensity (RIC)

160. Date pre-HCT preparative regimen began (irradiation or drugs): ___ ___ ___ ___ — ___ ___ — ___ ___
YYYY MM DD

**(Use earliest date from questions 164 radiation, or 169 – 316 chemotherapy)**

161. Was irradiation planned as part of the pre-HCT preparative regimen?

☐ Yes – ***Go to question 162***

☐ No – ***Go to question 169***

162. What was the prescribed radiation field?

☐ Total body

☐ Total body by tomotherapy

☐ Total lymphoid or nodal regions

☐ Thoracoabdominal region

163. Total prescribed dose: (dose per fraction x total number of fractions) ___ ___ ___ ___ ☐ Gy ☐ cGy

164. Date started: ___ ___ ___ ___ — ___ ___ — ___ ___
YYYY MMDD

165. Was the radiation fractionated?

☐ Yes – ***Go to questions 166***

☐ No – ***Go to question 169***

166. Prescribed dose per fraction: ___ ___ ___☐ Gy ☐ cGy

167. Number of days: *(include "rest" days)* ___

168. Total number of fractions: ___ ___

**Indicate the total prescribed cumulative dose for the preparative regimen:**

169. ALG, ALS, ATG, ATS

☐ Yes – ***Go to questions 170***

☐ No – ***Go to question 174***

170. Total prescribed dose ___ ___ ___ ___ mg/kg

171._____Date started: ___ ___ ___ ___ — ___ ___ — ___ ___
YYYY MM DD

172._____Specify source:

☐ ATGAM (horse) – ***Go to question 174***

- ☐ ATG – Fresenius (rabbit) – ***Go to question 174***
- ☐ Thymoglobulin (rabbit) – ***Go to question 174***
- ☐ Other – ***Go to question 173***

173._____Specify other source:

174._____Anthracycline

- ☐ Yes – ***Go to question 175***
- ☐ No – ***Go to question 191***

175._____Daunorubicin

- ☐ Yes – ***Go to questions 176***
- ☐ No – ***Go to question 178***

176. Total prescribed dose ___ ___ ___ ___ ☐ mg/m$^2$
☐ mg/kg

177._____Date started: ___ ___ ___ ___ — ___ ___ — ___ ___
YYYY MM DD

178._____Doxorubicin (Adriamycin)

- ☐ Yes – ***Go to questions 179***
- ☐ No – ***Go to question 181***

179. Total prescribed dose: ___ ___ ___ ___ ☐ mg/m$^2$
☐ mg/kg

180._____Date started: ___ ___ ___ ___ — ___ ___ — ___ ___
YYYY MM DD

181. Idarubicin

- ☐ Yes – ***Go to questions 182***
- ☐ No – ***Go to question 184***

182. Total prescribed dose ___ ___ ___ ___ ☐ mg/m$^2$
☐ mg/kg

183._____Date started: ___ ___ ___ ___ — ___ ___ — ___ ___
YYYY MM DD

184._____Rubidazone

☐ Yes – ***Go to questions 185***

☐ No – ***Go to question 187***

185. Total prescribed dose ___ ___ ___ ___ ☐ mg/m$^2$

☐ mg/kg

186._____Date started: ___ ___ ___ ___ — ___ ___ — ___ ___

YYYY MM DD

187._____Other anthracycline

☐ Yes – ***Go to questions 188***

☐ No – ***Go to question 191***

188. Total prescribed dose ___ ___ ___ ___ ☐ mg/m$^2$

☐ mg/kg

189. Date started: ___ ___ ___ ___ — ___ ___ — ___ ___

YYYY MM DD

190._____Specify other anthracycline:

191._____Bleomycin (BLM, Blenoxane)

☐ Yes – ***Go to questions 192***

☐ No – ***Go to question 194***

192. Total prescribed dose ___ ___ ___ ___ ☐ mg/m$^2$

☐ mg/kg

193._____Date started: ___ ___ ___ ___ — ___ ___ — ___ ___

YYYY MM DD

194. Busulfan (Myleran)

☐ Yes – ***Go to questions 195***

☐ No – ***Go to question 198***

195. Total prescribed dose ___ ___ ___ ___ ___ ☐ mg/m$^2$

☐ mg/kg

☐ Target total AUC (µmol x min/L)

196._____Date started: ___ ___ ___ ___ — ___ ___ — ___ ___

197._____Specify administration:

☐ Oral

☐ IV

☐ Both_____

198. Carboplatin

☐ Yes – ***Go to questions 199***

☐ No – ***Go to question 203***

199. Total prescribed dose ___ ___ ___ ___ ☐ mg/m$^2$

☐ mg/kg

200._____Date started: ___ ___ ___ ___ — ___ ___ — ___ ___

YYYY MM DD

201. Were pharmacokinetics performed to determine preparative regimen drug dosing?

☐ Yes – ***Go to question 202***

☐ No – ***Go to question 203***

202. Specify the target AUC: ___ ___ ___mg/mL/minute

203._____Cisplatin (Platinol, CDDP)

☐ Yes – ***Go to questions 204***

☐ No – ***Go to question 206***

204. Total prescribed dose ___ ___ ___ ___ ☐ mg/m$^2$

☐ mg/kg

205._____Date started: ___ ___ ___ ___ — ___ ___ — ___ ___

YYYY MM DD

206._____Cladribine (2-CdA, Leustatin)

☐ Yes – ***Go to questions 207***

☐ No – ***Go to question 209***

207. Total prescribed dose ___ ___ ___ ___ ☐ mg/m$^2$

☐ mg/kg

208. Date started: ___ ___ ___ ___ — ___ ___ — ___ ___

209._____Corticosteroids (excluding anti-nausea medication)

☐ Yes – ***Go to question 210***

☐ No – ***Go to question 223***

210._____Methylprednisolone (Solu-Medrol)

☐ Yes – ***Go to questions 211***

☐ No – ***Go to question 213***

211. Total prescribed dose ___ ___ ___ ___ ☐ mg/m$^2$

☐ mg/kg

212._____Date started: ___ ___ ___ ___ — ___ ___ — ___ ___

YYYY MM DD

213._____Prednisone

☐ Yes – ***Go to questions 214***

☐ No – ***Go to question 216***

214. Total prescribed dose ___ ___ ___ ___ ☐ mg/m$^2$

☐ mg/kg

215._____Date started: ___ ___ ___ ___ — ___ ___ — ___ ___

YYYY MM DD

216._____Dexamethasone

☐ Yes – ***Go to questions 217***

☐ No – ***Go to question 219***

217. Total prescribed dose ___ ___ ___ ___ ☐ mg/m$^2$

☐ mg/kg

218._____Date started: ___ ___ ___ ___ — ___ ___ — ___ ___

YYYY MM DD

219. Other corticosteroid

☐ Yes – ***Go to questions 220***

☐ No – ***Go to question 223***

220. Total prescribed dose ___ ___ ___ ___ ☐ mg/m$^2$

□ mg/kg

221._____Date started: ___ ___ ___ ___ — ___ ___ — ___ ___
YYYY MM DD

222._____Specify other corticosteroid:

223._____Cyclophosphamide (Cytoxan)

□ Yes – ***Go to questions 224***

□ No – ***Go to question 226***

224. Total prescribed dose ___ ___ ___ ___ □ mg/m$^2$

□ mg/kg

225._____Date started: ___ ___ ___ ___ — ___ ___ — ___ ___
YYYY MM DD

226._____Cytarabine (Ara-C)

□ Yes – ***Go to questions 227***

□ No – ***Go to question 229***

227. Total prescribed dose ___ ___ ___ ___ □ mg/m$^2$

□ mg/kg

228._____Date started: ___ ___ ___ ___ — ___ ___ — ___ ___
YYYY MM DD

229._____Etoposide (VP-16, VePesid)

□ Yes – ***Go to questions 230***

□ No – ***Go to question 232***

230. Total prescribed dose ___ ___ ___ ___ □ mg/m$^2$

□ mg/kg

231._____Date started: ___ ___ ___ ___ — ___ ___ — ___ ___
YYYY MM DD

232. Fludarabine

□ Yes – ***Go to questions 233***

□ No – ***Go to question 235***

233. Total prescribed dose ___ ___ ___ ___ □ mg/m$^2$

☐ mg/kg

234._____Date started: ___ ___ ___ ___ — ___ ___ — ___ ___
YYYY MM DD

235._____Ifosfamide

☐ Yes – ***Go to questions 236***

☐ No – ***Go to question 238***

236. Total prescribed dose ___ ___ ___ ___ ☐ mg/m$^2$

☐ mg/kg

237._____Date started: ___ ___ ___ ___ — ___ ___ — ___ ___
YYYY MM DD

238._____Intrathecal therapy (chemotherapy)

☐ Yes – ***Go to question 239***

☐ No – ***Go to question 252***

239._____Intrathecal cytarabine (IT Ara-C)

☐ Yes – ***Go to questions 240***

☐ No – ***Go to question 242***

240. Total prescribed dose ___ ___ ___ ___ ☐ mg/m$^2$

☐ mg/kg

241._____Date started: ___ ___ ___ ___ — ___ ___ — ___ ___
YYYY MM DD

242. Intrathecal methotrexate (IT MTX)

☐ Yes – ***Go to questions 243***

☐ No – ***Go to question 245***

243. Total prescribed dose ___ ___ ___ ___ ☐ mg/m$^2$

☐ mg/kg

244._____Date started: ___ ___ ___ ___ — ___ ___ — ___ ___
YYYY MM DD

245._____Intrathecal thiotepa

☐ Yes – ***Go to questions 246***

☐ No – ***Go to question 248***

246. Total prescribed dose ___ ___ ___ ___ ☐ mg/m$^2$

☐ mg/kg

247._____Date started: ___ ___ ___ ___ — ___ ___ — ___ ___

YYYY MM DD

248._____Other intrathecal drug

☐ Yes – ***Go to questions 249***

☐ No – ***Go to question 252***

249. Total prescribed dose ___ ___ ___ ___ ☐ mg/m$^2$

☐ mg/kg

250._____Date started: ___ ___ ___ ___ — ___ ___ — ___ ___

YYYY MM DD

251._____Specify other intrathecal drug:

252._____Melphalan (L-Pam)

☐ Yes – ***Go to questions 253***

☐ No – ***Go to question 256***

253. Total prescribed dose ___ ___ ___ ___ ☐ mg/m$^2$

☐ mg/kg

254._____Date started: ___ ___ ___ ___ — ___ ___ — ___ ___

YYYY MM DD

255. Specify administration:

☐ Oral

☐ IV

☐ Both

256._____Mitoxantrone (Novantrone)

☐ Yes – ***Go to questions 257***

☐ No – ***Go to question 259***

257. Total prescribed dose ___ ___ ___ ___ ☐ mg/m$^2$

☐ mg/kg

258._____Date started: ___ ___ ___ ___ — ___ ___ — ___ ___
YYYY MM DD

259._____Monoclonal antibody

☐ Yes – ***Go to question 260***

☐ No – ***Go to question 280***

260._____Radio labeled mAb

☐ Yes – ***Go to questions 251***

☐ No – ***Go to question 267***

261. Total prescribed dose of radioactive component: ___ ___ ___ ___ • ___

☐ mCi

☐ MBq

262._____Date started: ___ ___ ___ ___ — ___ ___ — ___ ___
YYYY MM DD

**Specify radio labeled mAb:**

263._____Tositumomab (Bexxar)

☐ Yes

☐ No

264._____Ibritumomab tiuxetan (Zevalin)

☐ Yes

☐ No

265. Other radio labeled mAb

☐ Yes – ***Go to question 266***

☐ No – ***Go to question 267***

266._____Specify other radio labeled mAb:

267._____Alemtuzumab (Campath)

☐ Yes – ***Go to questions 268***

☐ No – ***Go to question 270***

268. Total prescribed dose ___ ___ ___ ___ ☐ mg/m$^2$

☐ mg/kg

269._____Date started: ___ ___ ___ ___ — ___ ___ — ___ ___
YYYY MM DD

270._____Rituximab (Rituxan, anti CD20)

☐ Yes – ***Go to questions 271***

☐ No – ***Go to question 273***

271. Total prescribed dose ___ ___ ___ ___ ☐ mg/m$^2$

☐ mg/kg

272._____Date started: ___ ___ ___ ___ — ___ ___ — ___ ___
YYYY MM DD

273._____Gemtuzumab (Mylotarg, anti CD33)

☐ Yes – ***Go to questions 274***

☐ No – ***Go to question 276***

274. Total prescribed dose ___ ___ ___ ___ ☐ mg/m$^2$

☐ mg/kg

275._____Date started: ___ ___ ___ ___ — ___ ___ — ___ ___
YYYY MM DD

276._____Other mAb

☐ Yes – ***Go to questions 277***

☐ No – ***Go to question 280***

277. Total prescribed dose ___ ___ ___ ___ ☐ mg/m$^2$

☐ mg/kg

278. Date started: ___ ___ ___ ___ — ___ ___ — ___ ___
YYYY MM DD

279._____Specify other mAb:

280._____Nitrosourea

☐ Yes – ***Go to question 281***

☐ No – ***Go to question 291***

281._____Carmustine (BCNU)

☐ Yes – ***Go to questions 282***

☐ No – ***Go to question 284***

282. Total prescribed dose ___ ___ ___ ___ ☐ mg/m$^2$
☐ mg/kg

283._____Date started: ___ ___ ___ ___ — ___ ___ — ___ ___
YYYY MM DD

284._____CCNU (Lomustine)

☐ Yes – ***Go to questions 285***

☐ No – ***Go to question 287***

285. Total prescribed dose ___ ___ ___ ___ ☐ mg/m$^2$
☐ mg/kg

286._____Date started: ___ ___ ___ ___ — ___ ___ — ___ ___
YYYY MM DD

287._____Other nitrosourea

☐ Yes – ***Go to questions 288***

☐ No – ***Go to question 291***

288. Total prescribed dose ___ ___ ___ ___ ☐ mg/m$^2$
☐ mg/kg

289._____Date started: ___ ___ ___ ___ — ___ ___ — ___ ___
YYYY MM DD

290._____Specify other nitrosourea:

291. Paclitaxel (Taxol, Xyotax)

☐ Yes – ***Go to questions 292***

☐ No – ***Go to question 294***

292. Total prescribed dose ___ ___ ___ ___ ☐ mg/m$^2$
☐ mg/kg

293._____Date started: ___ ___ ___ ___ — ___ ___ — ___ ___
YYYY MM DD

294._____Teniposide (VM26)

☐ Yes – ***Go to questions 295***

☐ No – ***Go to question 297***

295. Total prescribed dose ___ ___ ___ ___ ☐ mg/m$^2$

☐ mg/kg

296._____Date started: ___ ___ ___ ___ — ___ ___ — ___ ___
YYYY MM DD

297. Thiotepa

☐ Yes – ***Go to questions 298***

☐ No – ***Go to question 300***

298. Total prescribed dose ___ ___ ___ ___ ☐ mg/m$^2$

☐ mg/kg

299._____Date started: ___ ___ ___ ___ — ___ ___ — ___ ___
YYYY MM DD

300._____Treosulfan

☐ Yes – ***Go to questions 301***

☐ No – ***Go to question 303***

301. Total prescribed dose ___ ___ ___ ___ ___ ☐ mg/m$^2$

☐ mg/kg

302._____Date started: ___ ___ ___ ___ — ___ ___ — ___ ___
YYYY MM DD

303. Tyrosine kinase inhibitors

☐ Yes – ***Go to questions 304***

☐ No – ***Go to question 313***

304. Dasatinib (Sprycel)

☐ Yes – ***Go to questions 305***

☐ No – ***Go to question 307***

305. Total prescribed dose ___ ___ ___ ___ ☐ mg/m$^2$

☐ mg/kg

306. Date started: ___ ___ ___ ___ — ___ ___ — ___ ___
YYYY MM DD

307. Imatinib mesylate (STI571, Gleevec)

☐ Yes – ***Go to questions 308***

☐ No – ***Go to question 310***

308. Total prescribed dose ___ ___ ___ ___ ☐ mg/m$^2$

☐ mg/kg

309. Date started: ___ ___ ___ ___ — ___ ___ — ___ ___

YYYY MM DD

310. Nilotinib

☐ Yes – ***Go to questions 311***

☐ No – ***Go to question 313***

311. Total prescribed dose ___ ___ ___ ___ ☐ mg/m$^2$

☐ mg/kg

312. Date started: ___ ___ ___ ___ — ___ ___ — ___ ___

YYYY MM DD

313._____Other drug

☐ Yes – ***Go to questions 314***

☐ No – ***Go to question 317***

314. Total prescribed dose ___ ___ ___ ___ ☐ mg/m$^2$

☐ mg/kg

315._____Date started: ___ ___ ___ ___ — ___ ___ — ___ ___

YYYY MM DD

316._____Specify other drug:

## GVHD Prophylaxis

**This section is to be completed for allogeneic HCTs only; autologous HCTs continue with question 344.**

7. Was **GVHD** prophylaxis planned / given?

☐ Yes - ***Go to questions 318***

☐ No - ***Go to question 344***

**Specify:**

318. ALG, ALS, ATG, ATS

☐ Yes – ***Go to question 319***

☐ No – ***Go to question 322***

319. Total dose: ___ ___ ___ ___ ___ mg/kg

320._____Specify source:

☐ ATGAM (horse) – ***Go to question 322***

☐ ATG – Fresenius (rabbit) – ***Go to question 3212***

☐ Thymoglobulin (rabbit) – ***Go to question 322***

☐ Other – ***Go to question 321***

321._____Specify other source:

322._____Corticosteroids (systemic)

☐ Yes

☐ No

323._____Cyclosporine (CSA, Neoral, Sandimmune)

☐ Yes

☐ No

324._____Cyclophosphamide (Cytoxan)

☐ Yes

☐ No

325._____Extra-corporeal photopheresis (ECP)

☐ Yes

☐ No

326._____FK 506 (Tacrolimus, Prograf)

☐ Yes

☐ No

327. In vivo monoclonal antibody

☐ Yes – ***Go to question 328***

☐ No – ***Go to question 335***

**Specify in vivo monoclonal antibody:**

328. Alemtuzumab (Campath)

☐ Yes

☐ No

329._____Anti CD 25 (Zenapax, Daclizumab, AntiTAC)

☐ Yes – ***Go to question 330***

☐ No – ***Go to question 331***

330._____Specify:

331._____Etanercept (Enbrel)

☐ Yes

☐ No

332._____Infliximab (Remicade)

☐ Yes

☐ No

333. Other in vivo monoclonal antibody

☐ Yes – ***Go to question 334***

☐ No – ***Go to question 335***

334._____Specify antibody:

335._____In vivo immunotoxin

☐ Yes – ***Go to question 336***

☐ No – ***Go to question 337***

336._____Specify immunotoxin:

337._____Methotrexate (MTX) (Amethopterin)

☐ Yes

☐ No

338._____Mycophenolate mofetil (MMF) (CellCept)

☐ Yes

☐ No

339._____Sirolimus (Rapamycin, Rapamune)

☐ Yes

☐ No

340._____Blinded randomized trial

☐ Yes – ***Go to question 341***

☐ No – ***Go to question 342***

341._____Specify trial agent:

342._____Other agent

☐ Yes – ***Go to question 343***

☐ No – ***Go to question 344***

343._____Specify other agent:

## Other Toxicity Modifying Regimen

**Optional for non-U.S. Centers**

4. Was KGF (palifermin, Kepivance) started or is there a plan to use it?

☐ Yes

☐ No

☐ Masked trial

## Post-HCT Disease Therapy Planned as of Day 0

5. Is this HCT part of a planned multiple (sequential) graft / HCT protocol?

☐ Yes

☐ No

6. Is additional post-HCT therapy planned?

☐ Yes - ***Go to questions 347***

☐ No - ***Go to First Name***

**Questions 347 – 357 are optional for non-U.S. centers**

347._____Bortezomib (Velcade)

☐ Yes

☐ No

348._____Cellular therapy (e.g. DCI, DLI)

☐ Yes

☐ No

349._____Dexamethasone

☐ Yes

☐ No

350._____Intrathecal therapy (chemotherapy)

☐ Yes

☐ No

351._____Tyrosine kinase inhibitor (e.g. imatinib mesylate)

☐ Yes

☐ No

352._____Lenalidomide (Revlimid)

☐ Yes

☐ No

353._____Local radiotherapy

☐ Yes

☐ No

354._____Rituximab (Rituxan, MabThera)

☐ Yes

☐ No

355._____Thalidomide (Thalomid)

☐ Yes

☐ No

356._____Other therapy

☐ Yes – ***Go to question 357***

☐ No – ***Go to First Name***

357._____Specify other therapy:

CIBMTR Center Number: ___ ___ ___ ___ ___ CIBMTR Research ID: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

First Name: _____

Last Name: _____

E-mail address: _____

Date: ___ ___ ___ ___ — ___ ___ — ___ ___

YYYY MM DD